



If you have questions, call:  
Department of Administration  
Office of Group Insurance  
650 W. State Street  
Boise, ID 83720-0035  
208-332-1860 or 1-800-531-0597  
ogi@adm.state.id.us

POLICY TYPE (please check one):

- ☐ High Deductible
- ☐ PPO
- ☐ Traditional

Date of Application: \_\_\_\_\_

Effective Date *(subject to BCI approval)*: \_\_\_\_\_

Group Number: 10040000

Please complete *each* section on the front and back page of this application in ink.

| Applicant Information (Employee)        |             |  |                                   |  |  |
|---|-------------|--|-----------------------------------|--|--|
| Your Name <i>(first, initial, last)</i> |             | Blue Cross ID Number<br><i>(if currently enrolled)</i>   | Social Security Number<br><br>/ / | Date of Birth<br><br>/ /                                       | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Mailing Address                         |             | City, State, Zip Code  |                                   | Phone Number<br><br>( )  |  |
| Hire Date                               | Rehire Date | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br>Common Law: <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Marriage: _____ |                                   | State <b>Department</b> or agency with which you are employed: |  |

**COMPLETE ONLY TO DECLINE ALL BENEFITS *(Do not complete the information below this box.)***  
I hereby decline **all** benefits and understand they may be added at a later date subject to waiting periods and other eligibility requirements as outlined in the State of Idaho member contract and employee handbook.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

| Type of Enrollment   | Change Request   |
|--|--|
| <b>MEDICAL</b><br><input type="checkbox"/> Self only<br><input type="checkbox"/> Self and spouse<br><input type="checkbox"/> Self, spouse and 1 child<br><input type="checkbox"/> Self, spouse and 2+ children<br><input type="checkbox"/> Self and 1 child<br><input type="checkbox"/> Self and 2+ children | <input type="checkbox"/> New Hire<br><input type="checkbox"/> Marriage<br><input type="checkbox"/> Death<br><input type="checkbox"/> Involuntary loss of coverage<br><input type="checkbox"/> Transfer<br><input type="checkbox"/> Divorce<br><input type="checkbox"/> Add Dependent<br><input type="checkbox"/> Court order (copy of court order required)<br><input type="checkbox"/> Adoption<br><input type="checkbox"/> Birth<br><input type="checkbox"/> Delete Dependent<br>Date event occurred: ____ / ____ / ____ |

**Dental Enrollment\* *(Dental benefits and eligibility not administered by Blue Cross of Idaho)***

☐ Self only      ☐ Self and dependents

**\*If I decline dental coverage for my dependents, I understand that they may not be added to coverage until the State of Idaho conducts a special open enrollment period.**

**Spouse & Eligible Children to be Enrolled *(list all family members you wish to enroll)***

|  |                                |  |                                     |  |
|--|--------------------------------|--|-------------------------------------|--|
| Family Member's Name <i>(first, initial, last)</i> | Social Security No.<br><br>/ / | Relationship to Applicant (spouse, child, stepchild, etc.) | Date of Birth (mm/dd/yy)<br><br>/ / | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | Social Security No.<br><br>/ / | Relationship to Applicant (spouse, child, stepchild, etc.) | Date of Birth (mm/dd/yy)<br><br>/ / | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | Social Security No.<br><br>/ / | Relationship to Applicant (spouse, child, stepchild, etc.) | Date of Birth (mm/dd/yy)<br><br>/ / | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | Social Security No.<br><br>/ / | Relationship to Applicant (spouse, child, stepchild, etc.) | Date of Birth (mm/dd/yy)<br><br>/ / | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | Social Security No.<br><br>/ / | Relationship to Applicant (spouse, child, stepchild, etc.) | Date of Birth (mm/dd/yy)<br><br>/ / | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |

**Is spouse a State of Idaho employee?**   ☐ YES   ☐ NO   If YES, spouse's name: \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Department:** \_\_\_\_\_

**SPOUSE MUST COMPLETE A SEPARATE APPLICATION TO ENROLL OR TO DECLINE COVERAGE.**

**Prior Coverage Information *(Please complete for proper crediting of waiting periods.)***

Has any person listed on this application been covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application?   ☐ Yes   ☐ No   If **YES**, please complete all information below for **each** person listed on this application.

| Applicant's Name | Name of Carrier | Policy Number | Type of Policy<br>(Group or Individual) | Date of Policy<br>Start Date      End Date<br>(mm/dd/yy)      (mm/dd/yy) |  |
|------------------|-----------------|---------------|---|--|--|
| Employee         |                 |               |   |  |  |
| Spouse           |                 |               |   |  |  |
| Child            |                 |               |   |  |  |
| Child            |                 |               |   |  |  |
| Child            |                 |               |   |  |  |

• If you have had other coverage with another carrier within 63 days of this request, please attach a copy of your **Certificate of Health Coverage** (HIPAA); this will ensure proper credit for any preexisting conditions, if applicable.

• If your coverage is terminated, please state reason: \_\_\_\_\_

Original applications must be submitted to your AGENCY HUMAN RESOURCES OFFICE

FOR OFFICE USE ONLY

| Group Number | Subgroup | HIPAA       |       |     | Effective Date | Plan ID |   |   | Class | Reason Code |
|--------------|----------|-------------|-------|-----|----------------|---------|---|---|-------|-------------|
| 10040000     |          | Credit Days | Start | End |                | M       | D | V |       |             |
|              |          |             |       |     |                |         |   |   |       |             |

If any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy?   ☐ Yes   ☒ No   If **YES**, please complete all information below for **each** person listed on this application.

| Applicant's Name | Name of Carrier | Policy Number | Type of Policy<br>(Group or Individual) | Start Date of Policy<br>(mm/dd/yy) | Will Current Policy Continue?*                                      |
|------------------|-----------------|---------------|---|------------------------------------|---|
| Employee         |                 |               |   |                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Spouse           |                 |               |   |                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Child            |                 |               |   |                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Child            |                 |               |   |                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Child            |                 |               |   |                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

If any person listed on this application is covered by Medicare, please complete the following:

Name\_\_\_\_\_

Date of Medicare Entitlement:

Part A

/

mmddyy

Medicare Beneficiary Number\_\_\_\_\_

Part B

/

mmddyy

Reason for Medicare Entitlement (age, disability of ESRD) \_\_\_\_\_

\* If your current coverage will remain active, please indicate if coverage is for:     ☐ Medical       ☐ Dental       ☐ Vision

\* If your current coverage will be terminated, please indicate termination date: \_\_\_\_\_

mm            dd            yy

Total disability is a condition resulting from disease or accidental injury, as certified in writing by an attending physician, that renders the enrollee/member incapable of performing the principal duties of regular employment/occupation for which he/she is qualified/trained and he/she is not engaged in any work, profession or avocation for fees, gain or profit; or he/she is unable to engage in the normal activities of an individual of the same age and gender.

**Are you or any of your dependents currently *totally* disabled?**   ☐ **YES**   ☐ **NO**   *(If YES, complete information below.)*

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*Nature of Total Disability*

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|  |                            |                                 |
|--|----------------------------|---------------------------------|
| <i>Name of Totally Disabled Person</i> | <i>Physician's Name</i>    | <i>Physician's Phone Number</i> |
| <hr/>                                  | <hr/>                      | <hr/>                           |
| <i>Date of Total Disability</i>        | <i>Physician's Address</i> |                                 |
| <hr/>                                  | <hr/>                      |                                 |

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at [www.bcidaho.com](http://www.bcidaho.com).
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.

A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

**APPLICATION MUST BE SIGNED AND DATED**

Signature \_\_\_\_\_

Date \_\_\_\_\_